

**0860: IMPROVING PLASTIC SURGERY TRAUMA CARE**C. Sethu\*, K.Y. Wong. *Queen Alexandra Hospital, UK*

**Aim:** The provision of plastic surgery trauma care varies widely between hospitals in the United Kingdom. We evaluate our trauma service and illustrate the use of quality improvement models to improve care.

**Methods:** All patients attending a plastic surgery trauma clinic at a single hospital over 3 consecutive months in 2014 were prospectively studied. Patient demographics, injury modality, diagnosis, timing of events, nil by mouth time, treatment delays, theatre efficiency, coding accuracy, costing, outcomes and complications were analysed.

**Results:** A total of 229 patients with a mean age of 43 years (range 1–92) were evaluated. Lacerations accounted for 58% of injuries. The majority of patients (74%) were seen within 24 hours of referral and 41% were discharged on the first visit.

Procedures were required for 82% of patients with 64% performed in the outpatient clinic and 34% in theatre. For the latter, 62% were operated within 24 h and the average time was 51 h (range 3–200). Over 75% of delays and cancellations were due to lack of capacity.

**Conclusion:** Delays in trauma treatment remain common as they are not target-driven. Using quality improvement models such as lean thinking and rapid cycle change we implemented solutions resulting in improved care.

**0872: PAEDIATRIC BURNS IN BLANTYRE, MALAWI: A FOLLOW UP STUDY**L. Harris<sup>1,\*</sup>, E. Fioratou<sup>1</sup>, E. Broadis<sup>2</sup>. <sup>1</sup> *University of Dundee, UK;* <sup>2</sup> *Royal Hospital for Sick Children Yorkhill, UK*

**Aim:** A burn prevention and education programme was implemented in Queen Elizabeth Central Hospital, Malawi between January 2010–2013. This study aimed to identify changes in aetiology and mortality of childhood burn injuries following the intervention and investigate the barriers and facilitators of implementing education-training programmes.

**Methods:** Retrospective data was collected for 173 children's admissions to the Burns Unit between February 2013–2014. Semi-structured interviews with 14 Malawian and Scottish staff delivering and receiving teaching at training education programmes were conducted. All interviews were recorded, transcribed and analysed using thematic analysis.

**Results:** Annual post-project mortality rate was 28.3%, an increase post project of 7.9%. A decrease from pre-project data remained. Rate of operative intervention decreased from 40% during project to 21.6% post. Overarching barriers and facilitators were similar for both sets of staff. Lack of practical training prevents Malawian staff utilising skills learned. Sustainability is essential to successful implementation of programmes. Lack of resources is likely to present greatest obstacle to implementing improvements.

**Conclusion:** Despite an increase in annual mortality, a sustained reduction in mortality existed from pre-project data. Recognition and response to barriers in introducing education-training programmes can contribute to the development of sustainable prevention programmes.

**0998: RE-RUPTURE OF FLEXOR TENDON REPAIRS**G. Kleiftouris\*, H. Shah, J. Srinivasan. *Royal Preston Hospital, UK*

**Aim:** Flexor tendon repair remains a challenge to surgeons. Despite the advances in operative techniques, and rehabilitation protocols, re-ruptures still occur. The aim of this study was to analyse tendon repairs and identify any areas that could improve outcomes.

**Methods:** That was a retrospective study which identified all patients who had a flexor tendon repair rupture between March 2011 and July 2013 in Royal Preston Hospital. Data collected included

**Results:** Fifteen patients with flexor tendon repair re-rupture were identified. All patients had the same rehabilitation protocol (i.e. modified Belfast protocol). Most injuries were in zone II and involved FDP tendon. The majority of patients had 4-strand modified Kessler repair with epitendinous suture. Only 2 patients reported a traumatic re-rupture – the rest patients did not report any trauma or signs of infection. In 8 patients repair failed in the first 6 weeks. Ultrasound scan confirmed re-rupture of the flexor tendon

only in 5 out of 9 patients who had a scan prior to surgery. The majority of patients had a secondary repair as a definite treatment.

**Conclusion:** Flexor tendon repair re-rupture is complex. Personalised surgical technique and rehabilitation protocol are crucial factors for overall good results.

**Posters: Surgical Training and Education****0029: SHOULD I TAKE A YEAR OUT TO HELP MY CST APPLICATION?**C. Devlin\*, A. Browning. *Pinderfields General Hospital, UK*

**Aim:** Increasing numbers of doctors are not entering into specialty training after completing the Foundation Programme, however, competition for a place on the national Core Surgical Training Programme increases year on year. The question often asked by Foundation doctors, is whether a year out would benefit my chance of a successful application to Core Surgical Training. The opinions of current core surgical trainees was sought to provide guidance on this.

**Methods:** We conducted a survey of the opinions of the Core Surgical trainees in the Yorkshire and Humber deanery via the Survey Monkey™ website.

**Results:** 59 responses were obtained. 18 trainees had not entered CST from F2. More than a third of responders felt foundation training had not provided enough time to prepare for CST application. Over 50% indicated they would have welcomed an extra year, helping to improve their portfolio and to gain extra experience.

**Conclusion:** The results show if used productively, focusing on surgery, a year out can benefit a CST application and improve overall experience. Also, in order to continue to attract the best candidates, surgery must become more willing to adapt to the changing attitudes on how future doctors wish to train.

**0038: MODEL INTRA-OPERATIVE DECISION MAKING: DOES IT REALLY EXIST? CREATION OF A VALIDATED QUESTIONNAIRE TO EXPLORE THE RELEVANCE OF EXISTING MODELS OF DECISION MAKING TO MODERN SURGICAL TRAINING**A. Bradley\*, K. Khan, E. Ross. *Hairmyres Hospital, UK*

**Aim:** To create a validated and reliable questionnaire that will enable exploration of intra-operative decision-making processes amongst UK surgical trainees and consultant surgeons.

**Methods:** A questionnaire was formulated in a step-wise fashion using qualitative and quantitative approach. Content validity and face validity were established through literature review and an online survey to gather opinions regarding positive and negative aspects and influences on intra-operative decision-making. Through qualitative feedback this was refined into a questionnaire. This anonymous questionnaire was distributed via email to all surgical trainees and consultant surgeons within the general surgical department.

**Results:** Construct validity, including convergent and discriminate validity, were proven. Criterion validity was established through comparison with existing models and outcomes from Non Operative Technical Skills for Surgeons (NOTSS) courses. Chronbach's  $\alpha$  coefficient scores ranged from 0.7 to 0.9, establishing internal reliability.

**Conclusion:** The questionnaire has proven validity and reliability. It will now be distributed to all UK surgical trainees. Results will aim to establish: i) applicability of existing decision making models to current practice, ii) whether decision making processes alter between clinical scenarios and over the course of surgical training, iii) form a basis from which to teach good intra-operative decision making skills.

**0069: TRAINEE-PERFORMED LAPAROSCOPIC SURGERY FOR INFLAMMATORY BOWEL DISEASE IS SAFE IN A SUPERVISED SETTING**V. Celentano, D. Finch\*, L. Forster, J. Robinson, J. Griffith. *Bradford Royal Infirmary, UK*

**Aim:** The aim of this study is to demonstrate that laparoscopic surgery for IBD performed by a surgical trainee under the supervision of an experienced trainer is feasible and safe.